recommends the French method of compressing instead of ligaturing the vessels. Separation of the bladder, opening into Douglas's pouch and lateral freeing of the cervix are performed as before; but so-called reversion of the uterus is avoided. An index finger is passed through Douglas's pouch and hooked around the upper border of the lateral ligament. The finger tip thus comes out through the front opening in the peritoneum. Along this finger one branch of the forceps is passed back and down so that its tip comes out through the opening into Douglas's cul-de-sac. The other forceps' arm is then inserted and the instrument locked. If one index finger does not suffice, the other must be passed in from the front, in which case an assistant adjusts the forceps. If the instrument has a firm hold, the uterus connections are severed along the inner border; whereupon the organ can be drawn down in front of the vulva, the other broad ligament treated in like manner and the uterus entirely removed. The forceps pass into the vagina only up to their locks. The vagina is washed with 1% borosalicylic and plugged with iodoform gauze for 48 hours, when the instruments are carefully opened and removed.

In the majority of cases the technical side of this procedure is not difficult. The plan controls hæmorrhage and greatly shortens the operation. The perhaps ulcerated cervix is not brought into contact with the peritoneum. The old danger from leaving instruments can be disregarded as we now know how to make them innoxious.

One of his cases ended fatally in 11 days, whether more from exhaustion or a slight peritonitis was uncertain. The others recovered, including two severe cases, one with cancerous adhesions.—*Centbl. f. Gynklg.*, 1887, No. 12.

WM. BROWNING (Brooklyn).

V. Hæmato-Salpingitis. By M. TERRILLON (Paris). Four patients with this disease were successfully treated by Terrillon by the removal of the affected tubes and ovaries. The symptoms were excessive metrorrhagia—constant in some, intermittent in others—violent pains in the abdomen generally constant, nausea, vomiting, wasting and feebleness. In all four the symptoms dated from a confinement; in two of them appearing on the return of the menstrual flow (in one

of these cases there had been a difficult labour); in a third case there had been puerperal pelvic peritonitis. The tubes were found covered with false membranes, matted to the ovaries, and adherent to the pelvic peritoneum.

In three of the cases the tubes were on one or the other side, distended with blood and clots to the size of a pigeon's or hen's egg; opening closed. Generally, both were affected, and in one case, where muco-pus occupied the tubes, the ovaries had suppurated. This was the case where there had been pelvic peritonitis.

On a minute examination Professor Cornil found in the specimens from three of the patients a similar condition. The principal change occurred in the mucous membrane which was hypertrophied, its folds exaggerated to form long and multiple fringes, partly filling the cavity. Where blood distended the tubes these fringes were flattened and atrophied: where there was muco-pus the vegetations were thickened and contained numerous embryonic cells. Orifices of bell-shaped openings were closed, fringes either atrophied and gone or thick and hypertrophied. Adhesions and bands united the tubes to the ovaries and to the peritoneum. The ovaries were enlarged, substance slightly altered, surface covered by false membranes.

The condition was summed up as inflammation of the lining of the tubes, which the clinical history showed to have begun in the uterus, spread outwards and after traversing the tubes caused localized peritonitis on and near the ovary, thus giving rise to the pain there. The hæmorrhage was due to the increased vascularity of the mucous membrane, the nervous and digestive symptoms to the reflex effects of the localised irritation. The organic lesions explained the uselessness of medical treatment of the symptoms and the necessity for surgical interference.—*Le Bull. Med.*, June 1, 1887.

VI. **Gonorrhœal Salpingitis.** By M. CORNIL (Paris). M. Cornil found acute bilateral salpingitis in the case of a young woman who died of pneumonia, and who at the time was suffering from gonorrhœa. On account of the delirium the date of the gonorrhœa could not be ascertained. There was exudation in tubes with numerous epithelial cells, but no gonococci were detected, papillary vegetation